

Facility Name & ID Number Lawrence Community Healthcare Center

0045617 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>15,277</u>	<u>8,426</u>	<u>3,650</u>	<u>27,353</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>15,277</u>	<u>8,426</u>	<u>3,650</u>	<u>27,353</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.70%

D. How many bed-hold days during this year were paid by the Department? 3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 08/02/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/02/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 3,650

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	168,408	28,907	10,703	208,018		208,018	(9,433)	198,585		1
2	Food Purchase		188,971		188,971		188,971	(288)	188,683		2
3	Housekeeping	165,208	40,308		205,516		205,516		205,516		3
4	Laundry	41,237	26,887	271	68,395		68,395		68,395		4
5	Heat and Other Utilities			90,901	90,901		90,901		90,901		5
6	Maintenance	26,553	7,742	69,832	104,127		104,127		104,127		6
7	Other (specify):*										7
8	TOTAL General Services	401,406	292,815	171,707	865,928		865,928	(9,721)	856,207		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,248,779	74,380	11,749	1,334,908		1,334,908		1,334,908		10
10a	Therapy			363,066	363,066		363,066		363,066		10a
11	Activities	64,466	1,235	1,533	67,234		67,234		67,234		11
12	Social Services	40,346		1,533	41,879		41,879		41,879		12
13	CNA Training										13
14	Program Transportation			3,550	3,550		3,550		3,550		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,353,591	75,615	383,831	1,813,037		1,813,037		1,813,037		16
	C. General Administration										
17	Administrative	85,424		265,592	351,016	(128,433)	222,583	(77,325)	145,258		17
18	Directors Fees										18
19	Professional Services			29,708	29,708	2,994	32,702		32,702		19
20	Dues, Fees, Subscriptions & Promotions			11,739	11,739		11,739	(5,013)	6,726		20
21	Clerical & General Office Expenses	49,604		70,315	119,919	96,855	216,774	(7,898)	208,876		21
22	Employee Benefits & Payroll Taxes			271,843	271,843	16,548	288,391		288,391		22
23	Inservice Training & Education			5,081	5,081		5,081		5,081		23
24	Travel and Seminar			18,854	18,854	1,974	20,828	(9,140)	11,688		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,075	64,075	574	64,649		64,649		26
27	Other (specify):* Litigation Fine			3,000	3,000		3,000	(3,000)			27
28	TOTAL General Administration	135,028		740,207	875,235	(9,488)	865,747	(102,376)	763,371		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,890,025	368,430	1,295,745	3,554,200	(9,488)	3,544,712	(112,097)	3,432,615		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			34,709	34,709	24,080	58,789	(8,286)	50,503			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,943	3,943	38,673	42,616	(5,113)	37,503			32
33	Real Estate Taxes			31,466	31,466		31,466		31,466			33
34	Rent-Facility & Grounds			145,493	145,493	(62,318)	83,175	(83,175)				34
35	Rent-Equipment & Vehicles					3,785	3,785		3,785			35
36	Other (specify):*											36
37	TOTAL Ownership			215,611	215,611	4,220	219,831	(96,574)	123,257			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			163,216	163,216		163,216		163,216			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Contributions			555	555	5,268	5,823	(5,823)				43
44	TOTAL Special Cost Centers			217,974	217,974	5,268	223,242	(5,823)	217,419			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,890,025	368,430	1,729,330	3,987,785		3,987,785	(214,494)	3,773,291			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,433)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,113)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(288)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,889)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(8,273)	24		19
20	Contributions	(5,823)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,009)	21		24
25	Fund Raising, Advertising and Promotional	(5,013)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,592)	17		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(12,153)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,586)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(158,908)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (158,908)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (214,494)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Lawrence Community Healthcare Center

ID# 0045617

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Owner out-of-state Travel	\$ (867)	24	1
2	Litigation Fine	(3,000)	27	2
3	Depreciation on Non-Care Assets	(8,286)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,153)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lawrence Community Healthcare Center# 0045617

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(9,433)	0	0	0	0	0	0	0	0	0	0	(9,433)	1
2	Food Purchase	(288)	0	0	0	0	0	0	0	0	0	0	(288)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,721)	0	0	0	0	0	0	0	0	0	0	(9,721)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,592)	(75,733)	0	0	0	0	0	0	0	0	0	(77,325)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,013)	0	0	0	0	0	0	0	0	0	0	(5,013)	20
21	Clerical & General Office Expenses	(7,898)	0	0	0	0	0	0	0	0	0	0	(7,898)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,140)	0	0	0	0	0	0	0	0	0	0	(9,140)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	27
28	TOTAL General Administration	(26,643)	(75,733)	0	(102,376)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,364)	(75,733)	0	(112,097)	29								

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center# 0045617

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(8,286)	0	0	0	0	0	0	0	0	0	0	(8,286)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,113)	0	0	0	0	0	0	0	0	0	0	(5,113)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(83,175)	0	0	0	0	0	0	0	0	0	(83,175)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(13,399)	(83,175)	0	(96,574)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,823)	0	0	0	0	0	0	0	0	0	0	(5,823)	43
44	TOTAL Special Cost Centers	(5,823)	0	0	0	0	0	0	0	0	0	0	(5,823)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(55,586)	(158,908)	0	(214,494)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 29						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 264,000	Rincker Healthcare Corporation	100.00%	\$ 188,267	\$ (75,733)	1
2	V	34 Facility Rental	145,493	William F. Rincker Trust		62,318	(83,175)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 409,493			\$ 250,585	\$ * (158,908)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	William J. Rincker		Management	20.00	20,172			Wages	\$ 12,827	17-1	1
2	Jane Rincker	Accounting Suprv.	Bookkeeping	20.00	117,859	10	0.25	Wages	74,939	21-1	2
3	Angela West		Management	20.00	20,172			Wages	12,827	17-1	3
4	Deanna Gillis		Management	20.00	33,672	5	0.25	Wages	12,827	17-1	4
5	William R. Gillis	Administrator	Management	20.00	28,242	32.5	0.81	Wages	103,195	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 216,615		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Rincker Healthcare Corporation
 Street Address 900 E. Corporation
 City / State / Zip Code Bridgeport, IL 62417
 Phone Number (618) 945-2091
 Fax Number (618) 945-9030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See Attached Schedule Pg 25				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	First Financial Bank NA	X	Purchase	\$8,437.77	08/02/96	\$ 1,014,000	\$ 593,441	09/15/2017	8.7500	\$ 38,238	1								
2	First Financial Bank NA	X	Purchase - Rincker Healthcare, See Page 25						7.2500	435	2								
3	Toyota Financial	X	Purchase - 2004 Sequoia	\$342.68	09/14/04	18,203		09/14/2009	4.9000	62	3								
4	Toyota Financial	X	Purchase - 2008 Sequoia	\$750.64	05/10/09	38,832	34,856	05/10/2014	5.9000	1,278	4								
5	First Financial Bank NA	X	Purchase - 2009 Ford E250	\$755.40	03/16/09	41,052	35,123	02/16/2014	5.9900	2,025	5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$10,286.49		\$ 1,112,087	\$ 663,420			\$ 42,038	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 1,112,087	\$ 663,420			\$ 42,038	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	29,552	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	30,509	2
3. Under or (over) accrual (line 2 minus line 1).		\$	957	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,509	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	31,466	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	30,731	8	
	2005	30,729	9	
	2006	30,731	10	
	2007	29,747	11	
	2008	30,509	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>52,541</u>	<u>1996</u>	<u>\$ 20,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	52,541		\$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1996		\$ 664,000	\$ 16,600	40	\$ 16,600	\$	\$ 224,100	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various Fully Depreciated Assets Thru 2009				42,752					42,752	9
10	Siding		1997		5,300	132	40	132		1,655	10
11	Fire Alarm System		1998		17,000	1,133	15	1,133		13,599	11
12	Concrete Pads		1998		734	49	15	49		555	12
13	Awning at back door		1998		890	60	15	60		674	13
14	Parking Lot		1999		1,029	77	10	77		1,029	14
15	Flooring/ Tiling		1999		12,600	105	10	105		12,600	15
16	Carpentry Work		1999		3,645	243	15	243		2,633	16
17	Bathroom Renovation		1999		3,570	238	15	238		2,559	17
18	Hot Water System		1999		10,500	700	15	700		7,525	18
19	Hand Rails		1999		3,520	234	15	234		2,521	19
20	Alarm System		1999		5,297	353	15	353		3,737	20
21	Replacement Windows		2000		3,864	258	15	258		2,534	21
22	Water Heater		2000		4,350	435	10	435		4,241	22
23	Flooring/ Tiling		2000		3,200	320	10	320		3,093	23
24	Plumbing		2000		1,719	86	20	86		824	24
25	Fire Suppression System		2000		1,849	74	25	74		697	25
26	Flooring/ Tiling		2000		2,600	260	10	260		2,448	26
27	Flooring/ Tiling		2001		4,450	445	10	445		4,005	27
28	Flooring/ Tiling		2001		3,340	334	10	334		2,978	28
29	Flooring/ Tiling		2001		3,150	315	10	315		2,809	29
30	Flooring/ Tiling		2001		4,450	445	10	445		3,968	30
31	Flooring/ Tiling		2001		2,625	262	10	262		2,339	31
32	Bi-fold doors		2001		1,665	167	10	167		1,458	32
33	120 gal Water Heater		2001		2,483	248	10	248		2,027	33
34	Water Heater		2002		2,961	296	10	296		2,344	34
35	Temperature Control Valve		2002		980	98	10	98		776	35
36	Chandaliers		2002		1,532	153	10	153		1,200	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Windows	2002	\$ 1,900	\$ 190	10	\$ 190		\$ 1,378	37
38	Carpet	2003	3,378	338	10	338		2,168	38
39	Carpet	2003	1,570	157	10	157		968	39
40	Water Softner	2003	2,103	211	10	211		1,281	40
41	Air Conditioning Units	2003	77,655	7,766	10	7,766		49,830	41
42	Sidewalk	2005	7,600	506	15	506		2,236	42
43	Storage Barn	2005	3,390	226	15	226		1,068	43
44	Doors	2005	5,042	252	20	252		1,197	44
45	Painting	2005	10,455	1,046	10	1,046		4,532	45
46	Hall Flooring	2007	1,987	199	10	199		530	46
47	Concrete Path	2007	3,045	203	15	203		524	47
48	Carpeting for Hall 4	2008	2,229	446	5	446		854	48
49	Roof Improvements	2008	18,117	1,812	10	1,812		2,869	49
50	Roof Improvements	2008	13,165	1,316	10	1,316		1,646	50
51	Water System	2009	9,570	479	10	479		479	51
52	3 Ton Rooftop A/C Unit	2009	2,874	287	5	287		287	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 980,135	\$ 39,554		\$ 39,554		\$ 425,527	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 58,436	\$ 5,246	\$ 5,246	\$		\$ 38,354	71
72	Current Year Purchases	10,315	572	572			572	72
73	Fully Depreciated Assets	504,692					504,692	73
74								74
75	TOTALS	\$ 573,443	\$ 5,818	\$ 5,818	\$		\$ 543,618	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	2008 Ford E250 Van	2009	\$ 41,052	\$ 5,131	\$ 5,131	\$	4	\$ 5,131	76
77										77
78										78
79										79
80	TOTALS			\$ 41,052	\$ 5,131	\$ 5,131	\$		\$ 5,131	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,614,630	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,503	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,503	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 974,276	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2004 Toyota Sequoia - Disposed	\$	\$ 3,237	\$	86
87	2008 Toyota Sequoia - Acq 2009	40,393	5,049	5,049	87
88					88
89					89
90					90
91	TOTALS	\$ 40,393	\$ 8,286	\$ 5,049	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,704	\$ 139,807	\$	2,704	\$ 139,807	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,350	67,818		1,350	67,818	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,320	155,251		3,320	155,251	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	7,374	\$ 362,876	\$	7,374	\$ 362,876	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 93,067	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	557,905		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,538		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	55,500		8
9	Other(specify): Employee Advances	2,255		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 712,265	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	161,953		15
16	Equipment, at Historical Cost	654,888		16
17	Accumulated Depreciation (book methods)	(627,733)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 189,108	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 901,373	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,434	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	14,791		29
30	Accrued Salaries Payable	26,880		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,592		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,509		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Insurance	40,191		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 205,397	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	55,187		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Owner Advances	511,113		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 566,300	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 771,697	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 129,676	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 901,373	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 196,288	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 196,288	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	333,389	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding Difference	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (66,612)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 129,676	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center# 0045617Report Period Beginning: 01/01/2009Ending: 12/31/2009**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,073,247	1
2	Discounts and Allowances for all Levels	(681,430)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,391,817	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	614,513	6
7	Oxygen	52,076	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 666,589	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,433	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	154,050	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,475	19
20	Radiology and X-Ray	6,537	20
21	Other Medical Services	73,160	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 257,655	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,113	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,113	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,321,174	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	865,928	31
32	Health Care	1,813,037	32
33	General Administration	875,235	33
B. Capital Expense			
34	Ownership	215,611	34
C. Ancillary Expense			
35	Special Cost Centers	163,216	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37	Charitable Contributions	555	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,987,785	40
41	Income before Income Taxes (line 30 minus line 40)**	333,389	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 333,389	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 26 If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,086	\$ 62,138	\$ 29.79	1
2	Assistant Director of Nursing	2,080	2,080	45,728	21.98	2
3	Registered Nurses	10,318	10,901	188,172	17.26	3
4	Licensed Practical Nurses	16,524	17,120	269,885	15.76	4
5	CNAs & Orderlies	73,816	76,273	662,894	8.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,048	2,142	20,533	9.59	9
10	Activity Assistants	5,371	5,501	43,933	7.99	10
11	Social Service Workers	3,571	3,792	40,346	10.64	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,086	24,057	11.53	13
14	Head Cook	3,399	3,605	29,363	8.15	14
15	Cook Helpers/Assistants	11,667	11,554	99,084	8.58	15
16	Dishwashers	1,961	2,034	15,903	7.82	16
17	Maintenance Workers	2,178	2,184	26,553	12.16	17
18	Housekeepers	19,535	19,979	165,208	8.27	18
19	Laundry	5,072	5,165	41,237	7.98	19
20	Administrator	2,080	2,086	85,425	40.95	20
21	Assistant Administrator	1,160	1,251	26,212	20.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,976	2,086	23,392	11.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,677	1,925	19,962	10.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,529	173,850	\$ 1,890,025 *	\$ 10.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	234	\$ 10,703	1-03	35
36	Medical Director	48	2,400	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,532	39-3	39
40	Physical Therapy Consultant	168	7,203	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	1,533	11-3	44
45	Social Service Consultant	15	1,533	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	480	\$ 26,904		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
William R. Gillis	Administrator	20	\$ 85,424	Workers' Compensation Insurance	\$ 73,838	IDPH License Fee	\$	
				Unemployment Compensation Insurance	23,977	Advertising: Employee Recruitment	3,152	
				FICA Taxes	151,079	Health Care Worker Background Check	720	
				Employee Health Insurance	39,497	(Indicate # of checks performed <u>45</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,419	
						License Fees	435	
						Other Advertising	5,013	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,424					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 288,391	Less: Public Relations Expense	()	
Replacement Taxes			\$ 1,592			Non-allowable advertising	(5,013)	
Management Fees			264,000			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 265,592	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Kemper CPA Group LLP	Accounting		\$ 21,042			\$	Out-of-State Travel	\$
Duane Morris	Legal		2,940				Administrative Travel - Airfare/gas	867
James Stout	Legal		275					
Kemper Technology Consulting	Computer Services		1,251				In-State Travel	
ADG Architecture & Design	Architect Fees		4,200				Program Transportation - Gas/oil, etc.	11,688
							Entertainment & Meals	8,272
							Seminar Expense	
							Administrative Travel	(867)
							Entertainment Expense	(8,272)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 29,708	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
						\$		\$ 11,688

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center

0045617

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 5 Adjustments, line 29

	<u>Amount</u>	<u>Line</u>
Owner out-of-state travel	\$ 867.00	24
Litigation Fine	3,000.00	27
Depreciation on Non-Care Assets	8,286.00	30
	<u>\$ 12,153.00</u>	

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There are no training fees because Lawrence Community Healthcare Center only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

Page 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

<u>Line Description</u>	<u>Amount</u>	<u>Line Ref</u>
Administrative	59,834	17
Professional Services	2,994	19
Clerical & General Office Expenses	96,855	21
Employee Benefits & Payroll Taxes	16,548	22
Travel and Seminar	1,974	24
Insurance - Prop.Liab.Malpractice	574	26
Interest	435	32
Rent - Equipment & Vehicles	3,785	35
Contributions	5,268	43
Administrative	<u>188,267</u>	17
Depreciation	24,080	30
Interest	<u>38,238</u>	32
Rent - Facility Grounds	<u>62,318</u>	34
Grand Total of allocated costs	<u><u>250,585</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT.

Reconciliation of taxable income to book net income

Book Net Income	\$ 333,389
Rounding Difference	3
Difference book vs. tax depreciation	(55,809)
Disallowed Meals & Entertainment	3,903
Accrual to cash conversion	<u>178,806</u>
Taxable Income	<u><u>\$ 460,292</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes.

	William J. Rincker	Angie West	Deanna Gillis	Jane Rincker	William Gillis
Friendship Manor	\$ 6,996.00	\$ 6,996.00	\$ 6,996.00	\$ 40,876.00	\$ 9,795.00
West Grove	6,180.00	6,180.00	19,680.00	36,107.00	8,652.00
Lawrence Comm. Healthcare Center	12,827.00	12,827.00	12,827.00	74,939.00	103,195.00
Rincker Residential	6,996.00	6,996.00	6,996.00	40,876.00	9,795.00
	<u>32,999.00</u>	<u>32,999.00</u>	<u>46,499.00</u>	<u>192,798.00</u>	<u>131,437.00</u>
Salaries reported on this cost report	<u>12,827.00</u>	<u>12,827.00</u>	<u>12,827.00</u>	<u>74,939.00</u>	<u>103,195.00</u>
Salaries reported by other homes	<u><u>\$ 20,172.00</u></u>	<u><u>\$ 20,172.00</u></u>	<u><u>\$ 33,672.00</u></u>	<u><u>\$ 117,859.00</u></u>	<u><u>\$ 28,242.00</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	<u>Land</u>	<u>Building & Improvements</u>	<u>Equipment</u>	<u>Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ -	\$ 161,953	\$ 573,443	\$ 81,445	\$ 816,841
Non-Care Assets	-	-	-	40,393	40,393
Schedule XI Ownership Costs	<u>20,000</u>	<u>980,135</u>	<u>573,443</u>	<u>41,052</u>	<u>1,614,630</u>
Difference	<u><u>\$ (20,000)</u></u>	<u><u>\$ (818,182)</u></u>	<u><u>\$ -</u></u>	<u><u>\$ -</u></u>	<u><u>\$ (838,182)</u></u>

On January 1, 2002, Lawrence Community Healthcare Center was incorporated. The real estate, building, and building improvements were not included. The facility is rented from a related party and the appropriate adjustments have been made on the cost report.

SEE ACCOUNTANTS' COMPILATION REPORT.

List of Related Parties (attachment to pg. 6)

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Angela West Trust	25%	West Grove, Inc.	Lawrenceville			
Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Angela West Trust	25%	Friendship Manor	St. Elmo			
Mary Jane Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Mary Jane Rincker Trust	25%	Friendship Manor	St. Elmo			
Deanna Gillis Trust	25%	West Grove, Inc.	Lawrenceville			
Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Deanna Gillis Trust	25%	Friendship Manor	St. Elmo			
William J. Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
William J. Rincker Trust	25%	Friendship Manor	St. Elmo			

SEE ACCOUNTANTS' COMPILATION REPORT.